**Texas Department of Insurance**
***Division of Workers' Comp***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

FOUNDATION SURGICAL HOSPITAL
5420 WEST LOOP SOUTH SUITE 3600
BELLAIRE TX 77401

**Respondent Name**

HARTFORD UNDERWRITERS INSURANCE

**Carrier's Austin Representative Box**

Box Number 47

**MFDR Tracking Number**

M4-12-0344-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** The requestor did not include a position summary in the DWC060 submitted to MDR.

**Amount in Dispute:** $5,327.51

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Reviewing the documentation submitted by the hospital, it did not appear that the admission justifies the DRG billed by the hospital. The facility has billed DRG 490 'Back & Neck Procedure except spinal fusion w/cc.' The length of stay was 2 days. The charges totaled $29,318.31. The provider's claim was reviewed by our Bill Reviewer's Medical Staff and we have issued a payment in line with DRG 491 'Back & Neck Procedure except spinal fusion w/o cc."

**Response Submitted by:** The Hartford, 300 S. State St., Syracuse, NY 13202

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 28, 2010 To September 30, 2010 | Inpatient Hospital Surgical Services | $5,327.51 | $6,562.62 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 22, 2010
   - 217 – THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY QMEDTRIX'S BILLCHEK SERVICE. FOR QUESTIONS REGARDING THE ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.
   - W1 – WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICING INCLUDED IN THE DRG RATE.

   Explanation of benefits dated September 8, 2011
   - Bill has been paid according to PPO contract.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. REIMBURSEMENT FOR RESUBMITTED INVOICE HAS BEEN CONSIDERED, NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO PPO CONTRACT.

**Issues**

1. Will the Division address the new issue raised by the respondent in their response to this dispute?
2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
3. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
4. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
5. Is the requestor entitled to reimbursement for the disputed services?

**Findings**

1. The respondent asserts in their response that after reviewing the documentation submitted by the hospital, it did not appear that the admission justifies the DRG billed by the hospital. Per 28 Texas Administrative Code §133.307(d)(2)(B), "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Per 28 Texas Administrative Code §133.307(d)(2)(B), this new issue will not be further addressed in this dispute review.
2. According to the explanation of benefits, the services in dispute were reduced pursuant to a PPO contract as described by Texas Labor Code §413.0115. Texas Labor Code Section §413.011(d-3) states that the division may request copies of each contract under which fees are being paid and goes on the state that the insurance

carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On February 17, 2012, the division requested a copy of the contract between the network and the health care provider, and documentation to support that the requestor was notified in accordance with 28 Texas Administrative Code §133.4. The carrier responded to the Division's request to provide a copy of the contract stating, "Please be advised that a contract does not apply in regards to this dispute." Consequently, the carrier is required to pay fees in accordance with 28 Texas Administrative Code §134.404 for the services in this dispute.

3. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
4. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
5. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011." Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 490 is $9,957.42. This amount multiplied by 143% is $14,239.11. The total maximum allowable reimbursement (MAR) is therefore $14,239.11. The respondent previously paid $7,676.49, therefore an additional amount of $6,562.62 is recommended for payment.

**Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,562.62.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,562.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 29, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.